DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX-43
Seattle, Washington 98121

October 1, 2006

Robin Arnold-Williams, Secretary
Department of Social and Health Services
P.O.Box 45010
Olympia, Washington 98504-5010

Dear Ms. Arnold-Williams:

Enclosed please find the Centers for Medicare & Medicaid Services' (CMS) draft report of the management review of the Washington Home and Community-Based Services (HCBS) waivers serving individual with Mental Retardation and/or Developmental Disabilities. These waivers have control numbers 408.04, 409.05, 410.03, and 411.04. Please review the attached report and the recommendations, and submit your comments within 30 days of receiving this letter. Please include comments and materials that you think may modify the substance of the findings, as well as a description of corrective action the State plans to make to address the identified problems. Your response, along with this draft report, will constitute the final report that is then available to the public.

The review included the extensive documentary evidence of compliance with the required assurances. The review team found that the State is in substantial compliance with all required assurance. Please express our appreciation to the entire Division of Developmental Disabilities staff for their assistance in the facilitation of the appraisal process. For further inquires, please contact Lydia Skeen at (206)615-2339 or Lydia.Skeen@cms.hhs.gov

Sincerely,

Karen O'Connor
Associate Regional Administrator
Division of Medicaid and Children's Health

cc: Kathy Leitch, Assistant Secretary
Aging and Disability Services

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
Region 10

DRAFT FEDERAL REPORT

Home and Community Based Services Waiver Assessment
Washington Waivers
Control # 408, 409, 410, & 411
Mental Retardation-Developmental Disability
2005-2006

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Home and Community-Based Waiver Services
Washington
Mental Retardation-Developmental Disability

Introduction:
Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs.

CMS must assess each home and community-based waiver program in order to determine that State assurances are met. This assessment also serves to inform CMS in its review of the State's request to renew the waiver.

Administrative agency:	Washington Department of Social and Health Services
Operating agency:	Division of Developmental Disabilities
State Waiver Contact:	Linda Rolfe
Target Population:	Developmental Disabled-Mental Retardation
Level of Care:	Refer to appropriate section below

Waiver Descriptions: Washington has four Mental Retardation (MR)-Developmental Disabled (DD) waivers which serve beneficiaries with varying levels of needs.

0408- Basic-MR/DD

Effective Dates: April 1, 2004 through March 30, 2007

People Served: Mentally Retarded/Developmental Disabled (MR/DD) clients who live with family or in their own homes. They meet Intermediate Care Facility for Mental Retardation (ICF/MR) Level of Care (LOC) guidelines but have a strong natural support system. The family / caregivers ability to continue caring for the client is at risk but can be continued with additional services. These clients at risk due to:

- The individual needs support to maintain his/her home or to participate successfully in the community; or
- The individual has physical assistance needs or medical problems requiring extra care; or
- The individual has behavior episodes which challenge the family or caregiver's ability to support them; or
- The family or care giver needs temporary or ongoing support due to his/her own physical, medical or psychiatric disability to continue helping the individual.

Level of Care: ICF/MR

Services	Yearly Limit
Behavior Management & Consultation Community Guide Environmental Accessibility Adaptations Specialized Medical Equipment/Supplies Occupational Therapy Specialized Psychiatric Services Physical Therapy Speech, Hearing and Language Services Staff/Family Consultation and Training Transportation	$1425 per year on any combination
Person-to-Person Supported Employment Community Access Pre-vocational Services	May not exceed $6500 per year
Mental Health Stabilization Services Behavior Management and Consultation Mental health crisis diversion bed services Specialized Psychiatric Services Skilled nursing	Limits determined by Mental Health or Division of Developmental Disability
Personal Care	Limits determined by the CARE assessment
Respite Care	Limits determined by respite assessment
Emergency Assistance	$6000 per year; pre-authorization required

Unduplicated Recipients:

Year 1: 3,965
Year 2: 3,806
Year 3: 3,654

0409- Basic Waiver Plus

Effective dates: April 1, 2004 through March 30, 2007

People Served: MR/DD clients who live with family or in another setting with assistance. They meet ICF/MR guidelines and are at high risk of out-of- home placement or loss of current living situation due to:

- Abuse, neglect or exploitation of the individual within the last six months;
- Return from out of home placement within the previous six months;
- A serious medical problem requiring close monitoring or specialized treatment;
- Dual diagnosis of Developmental Disability and a major Mental Illness or substance abuse;
- Challenging behavior resulting in danger to health or safety;
- Family / caregiver needs significant help to provide direct physical assistance to assure the health and safety of the individual;
- The individual has significant functional limitations resulting in a need for frequent assistance to maintain his/her home to successfully participate in the community; or
- The individual has protective supervision needs due to impaired judgment.

Level of Care: ICF/MR

Services	**Yearly Limits**
Skilled Nursing and all of the general services in the Basic Waiver	$6070 per year on any combination
Person to Person Supported Employment Community Access Pre-vocational Services	May not exceed $9500 per year In some situations, this limit may be increased to a maximum of $19,000 based on assessed client need and only with prior authorization.
Mental Health Stabilization Services Behavior Management and Consultation Mental health crisis diversion bed services Specialized Psychiatric Services Skilled nursing	Limits determined by Mental Health or Division of Developmental Disability(DDD)
Personal Care	Limits determined by the Comprehensive, Assessment, Reporting & evaluation (CARE) assessment tool
Respite Care	Limits determined by respite assessment

Adult Foster Care (Adult Family Home) Adult Residential Care (Boarding Home)	Determined per department rate structure in CARE $6000 per year; pre-authorization required
Emergency Assistance	

Unduplicated Recipients:
Year 1: 2211
Year 2: 2122
Year 3: 2038

0410- CORE (MR/DD)

Effective Dates: April 1, 2004 through March 30, 2007

People Served: MR/DD as defined in WAC 388-825-030 and implemented by WAC 388-825-035. The individuals on this waiver require residential habilitation services or live at home but are at immediate risk of out of home placement due to one or more of the following extraordinary needs:

- The individual has extreme and frequently occurring behavior challenges resulting in danger to health or safety, or
- Has had 18 or more days of inpatient psychiatric care in the past 12 months, or
- The individual lives in an ICF/MR and requests community placement, or
- Requires daily to weekly one-on-one support, supervision and 24 hour access to trained others to meet basic health and safety needs.

Level of Care: Nursing Facility

Services	**Yearly Limit**
Residential Habilitation and all of the Basic Plus services except Emergency Assistance, Adult Family Home and Adult Residential Care services	Limited to the average cost of an ICF/MR for any combination of services necessary to meet assessed client need

Unduplicated Recipients:
Year 1: 4273
Year 2: 4102
Year 3: 3938

0411- Community/Public Safety

Effective Dates: January 1, 2004 through March 30, 2007

People Served: MR/DD, 18 years or older. Other Criteria:

- Individuals on this waiver must meet the ICF/MR LOC
- Live or are moving into the community
- Require 24 hour, on-site, awake staff supervision to ensure the safety of others; and
- Require therapies and other forms of habilitation and are found by DDD to meet the criteria for "community protection".

Level of Care: ICF/MR

Services	Yearly Limits
All Core services except Personal Care, Respite, Community Guide, and Community Access. Note: some definitions differ in this waiver.	Limited to the average cost of an ICF/MR for any combination of services necessary to meet assessed client need. Residential services are offered only in DDD Certified Supported Living. Client must agree to Community Protection care plan.

Unduplicated Recipients:

Year 1: 342
Year 2: 328
Year 3: 315

General Waiver Eligibility

- The individual is a client of Division of Developmental Disability (DDD).
- The individual has a disability according to criteria established in the Social Security Act.
- The individual's gross income does not exceed 300 percent of the SSI benefit amount, and the individual's resources do not exceed $2,000. Parental income is not considered for children.
- The individual needs the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
- A Plan of Care (POC) has been prepared, which shows how the individual's health, safety and habilitation needs will be met in the community.
- The individual has agreed to accept home and community-based services as an alternative to institutional services.

Basic Waiver Targeting Criteria

- The individual on this waiver live with family or in their own homes.
- They meet ICF/MR level of care guidelines, but have a strong natural support system.

- The family/caregiver's ability to continue caring for the individual is at risk, but can be continued with the addition of services provided in the Basic Waiver.
- The individual does not need out-of home residential services.

Basic Plus Waiver Targeting Criteria

- The individuals on this waiver live with family or in another setting with assistance.
- Individuals may live in an adult family home or adult residential care facility.
- They meet ICF/MR guidelines and are at high risk of out-of-home placement or loss of current living situation.
- Individuals in this waiver require a higher a higher level of services than those in the Basic Waiver and/or nursing service.

Core Waiver Targeting Criteria

- The individuals on this waiver are at immediate risk of out-of-placement or are receiving residential habilitation services from a Division of Developmental Disability (DDD) contracted residential provider.

Community Protection Waiver Targeting Criteria

Individuals on this waiver meet the criteria for ICF/MR level of care and:

- Meet the Division of Developmental Disability criteria for "community protection";
- Require 24-hour, on-site, staff supervision to ensure the safety of others;
- Require therapies and/or other habilitation services; and
- Agree to receive services from a certified Community Protection Supported Living Provider.

CMS Contact:

Lydia Skeen
Lydia.Skeen@cms.hhs.gov
(206) 615-2339

EXECUTIVE SUMMARY

On April 1, 2004 the Centers for Medicare & Medicaid Services (CMS) approved Washington's Developmental Disabled-Mental Retardation waivers for a period of three years. These important programs provides home and community-based services targeted to Mentally Retarded and Developmentally Disabled individuals who are classified in one of four categories; Basic, Basic Plus, Core, and Community Protection levels (refer to waiver descriptions pages 3 to 8).

In accordance with 42 CFR 441.304, CMS conducted an extensive management review of all Mental Retardation-Developmental Disabled waivers in November 2005 through June 2006. All four waivers are administered by the Division of Developmental Disabilities. The State provided an extensive report that only partially demonstrates the evidence required to validate each of the six required assurances. The report documented the State's current processes, provided responses to the probing questions, and chronicled evidence to demonstrate compliance with the waiver requirements. The evidence provided to CMS reviewers documented that while the State has greatly improved the system infrastructure, there is insufficient evidence of follow through at the direct patient care or provider level. The following briefly summarizes the findings in each of the six required assurances.

- The evidence provided demonstrates that the State implemented a level of care evaluation system.

- The evidence provided demonstrates that the State has developed an electronic Quality Assurance monitoring software application for social services. Statewide implementation began in July 2004. The Quality Assurance staff use this tool for high-risk clients to help assure positive outcomes based on the client's plan of care.

- The evidence provided demonstrates that the State is in the process of developing a oversight monitoring, follow up, and corrective action process to assure that only qualified providers serve waiver participants.

- The evidence provided demonstrates that the State has developed a process to monitor the health and welfare of waiver participants. The State's new electronic Quality Assurance Monitoring system software is used as part of an 18-month quality assurance and improvement cycle.

- The evidence provided demonstrates that the State Medicaid agency retains administrative authority over the waiver program.

- The evidence provided demonstrates that the State has partially developed processes to monitor financial accountability for the waiver. Financial audits are completed on a local and regional level for developmental disability/mental retardation eligibility by local, regional and headquarters staff.

COMMENDATIONS

CMS commends the State in the following areas of improvement and positive practices.

1. There have been substantial improvements in many areas since the last review of the MR/DD waiver in 2003 including quality protocols, policies and procedures, and in-service training. Based on these improvements many of the recommendations focus on the next level of progress.
2. The video regarding complaints and grievances is extraordinary. The Regional Office will be submitting it to the CMS Central Office with a best practice nomination.
3. The developments in the Quality Assurance area are significant. CMS reviewers attended the Quality Council that is composed of consumers, advocates, and stakeholders. This is an active viable committee that was involved in preparing for the review.
4. There has been a significant increase in the number of case managers (a problem identified in the CAP reviews of 2001-2002 and 2003).
5. There is evidence of improved training and performance by the Developmental Disability regional office.
6. Several impressive databases and websites have been built. Those of note include: the case management training data base, the provider licensing data base, and the complaint tracking and Incident Report System.
7. CMS especially commends the State of Washington, DDD for use of Six Sigma techniques (Pareto Chart) in the data analysis and determination of the relative important difference between groups of data.
8. The stakeholders defined several areas in which the State has made significant progress, including:
    - o New training for the staff regarding waiver rules and regulations has been undertaken.
    - o New quality assurance protocols have been developed and are being implemented
    - o The Division has added more case managers.
    - o New forms for collection of waiver information have been implemented.
    - o New and better trained DD/MR central office staff has been assigned to monitor the waivers.
    - o The division is developing new automated assessment system.
    - o Clients supported by residential staff seem to be receiving increased hours of care as needs change.

9. The Division participates in the National Core Indicators program. Additionally, the state monitors the quality of state plan only services..
10. The State in the form of Quality Assessment reviews has in place follow-up programs in which the client status is reviewed with 60 days, 6 months, and 12 months of de-institutionalization.
11. Since the time of the settlement of the Marr and Allen lawsuits the state has been monitored on a semi-annual basis for compliance with the court requirements, Washington Administrative code (WAC), and best practices for the dually diagnosed (Mental Health and Developmentally Disabled). These reports demonstrate the Divisions continuing

efforts to improve the programs administered by DDD.

12. The State has implemented a new complaint resolution unit (CRU) to investigate incidents and to review the supported living facility providers. The reviewers have hands-on experience with the Mentally Retarded/Developmentally Disabled clients and providers, which was not historically true. CMS, during the review, received broad general approval and support from providers and advocates regarding this program improvement.

RECOMMENDATIONS

1. Division needs to develop an "executive summary" of its Quality Management Plan.

2. Senior Management must annually review and approve the Division quality management strategy. A signature page or some other form of verification of this review is required.

3. Review of the evidence, in forms of minutes and policies demonstrated inconsistency in the follow through with Quality Assurance (QA) findings and recommendations.

4. The Division must establish an oversight system for all its providers. Special reference is made to those clients that receive services from the Community Protection services providers. This oversight also applies to county providers in terms of the contract deliverables for supported employment and day programs. All services provided to DD waiver clients are the oversight responsibility of the Division.

5. The quarterly operations reports submitted to the Division Director contain evidence of quality practice. This information needs to be consolidated and periodically reported to the QA oversight committee.

6. During the review, CMS analyzed numerous complaints. At that time there were no outstanding complaints that had not been investigated. In these instances the Division appears to be in compliance with approved procedures/process. However, there was insufficient evidence that there is consistent investigation, follow-up, and corrective action. The State has implemented the new CRU process which appears to be improving the states process in this area.

7. Stronger oversight is mandatory for clients on the Community Protection waiver. The State reported there have been no incidents involving the community at large. However, there were several instances of elopement and/or assaultive behavior (client on client and client on staff) as documented in the clinical records.

8. It is strongly recommended that the division develop a process for periodically evaluating the waiting list (know as the database) and document this evaluation of the clients for movement onto the waivers.

9. In regard to the monthly service or monthly monitoring requirements, a system must be in place to assure that recipients who do not utilize services on a monthly basis are monitored.

10. The plans of care should include a section which specifically lists clients' identified (and measurable) goals.

11. Although significantly improved, CMS again recommends an increase in the number of case managers. The current minimum case load for case managers is 75 to 1. This is a significant workload for individuals who must insure the health and welfare of several severely compromised individuals. CMS findings are substantiated in detail in the report of the Developmental Disabilities Council, "Washington State Core Indicators Workgroup Findings", July, 2005.

12. The results of the records review for individuals receiving services identified below need continued focus. CMS observed that the State during the time period of the review had made significant improvement in the quality and quantity of documentation regarding the clients. CMS recommends the following areas for continued emphasis in the state's development efforts.

    - The Division should monitor of programs to assure that they are being implemented consistently and correctly, by all level of providers.

    - The Division needs evidence that there is monitoring of the integration and coordination of client's treatment plan by the providers.

    - The Division should monitor that the interventions described in the positive behavioral plans are appropriate and that all clients have a positive behavioral plan. During the on-site review many clients did not have behavioral plans developed, and it was felt (by the providers) to be currently not needed. CMS also questions the practice of having the provider develop the behavioral health plan. This should be the obligation of the case manager with provider input.

    - The Division needs increased evidence that its training programs which are available are utilized by relevant staff, including staff of other agencies that work with the client.

13. The Division needs to develop an inter-rate reliability system to further validate the findings in the assessment and quality processes.

14. Interviews with providers, state quality assurance staff, and clients uniformly support the finding that the greatest deficiency is the quality, quantity and timeliness of supported employment and day programs. This includes increased emphasis on definitive position placement of clients in a reasonable timeframe.

BACKGROUND AND DESCRIPTION

These waivers were approved under section 1915 (c) of the Social Security Act (the Act) as a statutory alternative to Medicaid-funded institutional care. The Secretary of Health and Human Services initially approved this waiver with an effective date April 1, 2004. The current effective period is April 1, 2004 through March 30, 2007. The State was granted waivers to Section 1902(a)(10)(B) of the Social Security Act in order to provide home and community-based services to mentally retarded and developmentally disabled individuals who meet the eligibility and level of care criteria identified in this report.

In November 2005 and June 2006, the Centers for Medicare & Medicaid Services (CMS) conducted a management assessment of the State's currently approved waivers. These reviews were comprehensive in scope and addressed all six assurances defined in the protocol, as revised by the interim guidance procedures of 2004. The team from the Seattle Regional Office of CMS used the *Regional Office Protocol for Conducting Reviews of State Medicaid HCBS Waiver Programs, December 20, 2000 version* to conduct the review. The protocol reflects a national effort to standardize the HCBS waiver reviews, with an emphasis on quality assurance. In June 2006 CMS performed a follow up focused management review. The concentration of the June review was on the assessment of the states continuous oversight of providers and clients, the extent to which the state's policies and procedures have been implemented, and extensive provider interviews and input (refer to Section 10, item 10 for details) This report follows the protocol in addressing areas assessed in the review process and indicates key findings and recommendations as appropriate. The CMS review focused on statutory requirements under section 1915(c)(2)(A) of the Act requiring states to assure that:

- Necessary safeguards have been taken to protect clients' health and welfare
- Necessary safeguards have been taken to assure financial accountability
- Waiver enrollees meet the appropriate level of care consistent with the need for institutionalization
- Consumer freedom of choice is assured in selecting available care alternatives
- Cost neutrality is maintained relative to the cost of institutional care
- Plans of care are individualized and responsive to waiver participant needs

The Washington Department of Social and Health Services (DSHS) is the Single State Medicaid Agency responsible for administering home and community-based services in Washington. The CMS review documented that the State was in substantial compliance with the federal waiver requirements. The State has taken an aggressive role in the development and implementation of the required State-level Quality Improvement System.

Lydia Skeen, Health Insurance Specialist, Wendy Hill-Petras, Health Insurance Specialist, Captain David Kerschner USPHS, R.N., ICF/MR Specialist, and Mary Bryant, Financial Management Specialist of the CMS Seattle Regional Office conducted the review.

I. The State Conducts Level of Need Determinations Consistent with the Need for Institutionalization.

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with care provided in a hospital, nursing facility or ICF/MF
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5; SMM 4442.6

The State substantially meets this assurance

Evidence:

1. "Mini-Assessment" Tool
2. All CARE assessment tools
3. JLARC Reports
4. CARE policy and procedures
5. Detailed review of records sample
6. "Database" waiting list

Observations:

1. The state performs a "mini" assessment to determine if the client meets the level of care. Clients who qualify are placed on the waiting list known as the "database". This establishes eligibility to move to a waiver when a "slot" becomes available. The "mini" assessment was developed in response to the JLARC report and has not been reviewed or approved by CMS for waiver participants. The mini assessment does not guarantee services.
2. The clients with no current service needs or who are identified as having only personal care needs maybe classified as low or medium. These classes do not receive active or current paid services. Those individuals who might qualify for Personal Care Services are referred for further assessment and possible services.
3. Clients are reassessed with the approved LOC assessment tool (CARE) if and when they are eligible for consideration for movement to one of the waivers.
4. The State used individual assessment tools for (a) personal care (b) respite care assessment (c) children's out of home assessment (d) CARE tool (e) plan of care document, and (f) level of care tool.
5. Current waiver participants will not be assessed by the new intake and eligibility assessment tool which is in development.

Recommendations:

1. The division should expedite the implementation of the comprehensive intake and eligibility assessment tools currently scheduled for November 2006.
2. The tools must be reviewed and approved by CMS prior to use. Additionally, the tool must be shown to be comparable to the criteria/tool used to evaluate clients for admission to ICF/MR facilities. Further, CMS questions how clients who are not in need of services

can meet the waiver criteria including the requirement that "clients are expected to require services (within the next 30 day) to avoid institutionalization.
3. The division is encouraged to petition the legislature for additional funded "slots" to place individuals in the waivers.
4. The division should develop a system for periodic reassessment of the individuals on the waiting list. This would include establishment of movement of clients in to the waivers prior to clients reaching crisis level.
5. The division must establish a system that provides evidence that assessments identify whether clients' skills, abilities, and training needs are being met.

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of plans of care for waiver participants.
Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13

The State substantially meets this assurance

Evidence:

1. Appeals and grievances logs.
2. Policy and Procedures.
3. Sample client records-specifically for Plans of Care.
4. Interviews with providers.
5. Interviews with Quality Assurance Staff
6. Individual client freedom of choice forms, policies, and procedures.

Observations:

1. The division during the on-site interviews, repeatedly assured CMS clients receives either a specific waiver service or a "monitoring" call on a monthly basis.
2. The division provided evidence that clients are afforded their right of appeal for any change in the plan of care, service volume, choice of providers, or other criteria of care.
3. The POCs reviewed did not clearly provide the clients measurable goals.
4. The clinical records and POC did not document that the client is given the choice between the community services and the institutional options. (The state indicated that this will be added to the final electronic version which is under development)
5. The monitoring report for the POCs demonstrated that the state had reviewed POCs for (a) annual re-evaluations (b) appeals if POC changes, and (c) training curriculum for case managers.
6. The division presented evidence that it had corrected deficiencies isolated during the monitoring phase.

Recommendations:

1. The Division must develop a documented system to verify that the clients are monitored in those cases where no monthly services are rendered.
2. The Division must produce evidence that it developed formal written training programs that described methods to be used, measurable objectives, data and frequency of data collection necessary to determine client needs and be able to assess progress toward meeting those needs.
3. The Division must develop a system that behavior plans in the POC describe interventions for inappropriate client behavior.
4. The Division must assure that active treatment was consistently implemented in all relevant settings, both formally and informally as the need arises or opportunities present themselves.
5. The Division must assure that the POC provides for each client to receive treatment and services in sufficient number and frequency to support the achievement of client objectives.
6. The Division must assure that the POC evidences that each individual's performance is accurately measured and programs are modified based on data and major life changes.
7. The POC should have a section which specifically lists the clients' identified (and measurable) goals.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. *Authority: 42 CFR 441.302: SMM 4441.4*

The state substantially meets this assurancewe

Evidence:

1. Evaluations Reports for RCS.
2. County Contracts Monitoring Reports.
3. Monitoring Reports for Marr and Allen lawsuits.
4. County Monitoring Policies and Procedures.
5. Specialized training plans.
6. Quality assurance Country Monitoring Policies and Procedures.
7. Certification Evaluation Reports for Residential Care Services, specifically:
    a. VOA of Western Washington
    b. Citizen Access Residential Resources (CARR)
    c. SL Start & Associate, Inc
    d. Aacres-Allvest
    e. Community Integrated Services
8. All Marr/Allen Monitoring Committee Reports for 2004, 2005 and 2006. (This regards the lawsuits brought by individual in both Western and Eastern State hospitals regarding

services to clients who are dually diagnosis as Mentally Retarded/Developmental Disabled and suffering from Mental Health issues)

Comments:

1. The Division provided evidence of monitoring that providers have valid contracts for authorized waiver services within the last three months.
2. The Division provided reports of evaluations of residential care services, certification letters to providers and Residential Care Survey (RCS) certification for supported living agencies.
3. The division provided evidence of corrective action for supported living agencies and evaluations of companion homes.
4. The county contract monitoring system, background check and other system were reviewed by CMS as evidence of compliance with this assurance.
5. The division has developed a specialized training program for Community Protection providers.
6. County Contract Monitoring Plans and risk assessment worksheets for the providers identified below:

County	Vendor	Type **
Clallam	Morningside	GSE/IE
Clark	Keys to Advancement	IE/PTP/CA/IFA
Cowlitz	Independent Associates	PTP/CA/GSE/IE
Jefferson	Holly Ridge Center	CDS
	Leslie Bunton	PTP
King	At Work	PTP/SI/CA/GSE/IE
	Cares of Washington	GSE/IE/PTP
	Seattle Lighthouse for the Blind	GSE/SI
	Trillium-Intensive	IE/PTP
Mason	Exceptional Foresters	SI/IE/CA/GSE
Pierce	Good Samaritans Bridges to Independence	CA
	Tacoma Learning Center	SI/CDES/GSE/IE
	Centerforce	IFA/PTP/SI/CA/GSE/IE
	Puget Sound Assisted Living	CA/PTP/CA
	WISE	IFA/PTP
Skagit	SPARC	CDS
Snohomish	Career Connections	IE/SI
	Sherwood Enterprises	PTP/CA/CDS/GSE
Spokane	Arc of Spokane	CA/GSE/IE
	Children First	CDS
	Community Colleges of Spokane	CDS
	East Central Community Center	CA

	Guild's School	CDS
	Pace Services	CA/IE
	The Artisans	IE/CA/GSE
Thurston	Employment Solutions Plus	CA/IE
Whatcom	Local Focus	CA/PTP
	Whatcom County Council on Aging	CA
Yakima	Central Washington Center for the Deaf	IE

** refer to acronyms list for complete definitions.

7. During the review the provider community was extensively interviewed. Included, were the following residential, day program, and employment providers.

- Community Integrated Services, CPC (Community Protection Client) residential provider
- Citizen Access Residential Resources (CARR), CPC and CORE Waiver provider
- Aacres-Allvest, LLC, CPC and CORE residential provider
- Ray Jensen, King County Development Disability, Employment Contractor
- Community Living, CP and CORE residential provider
- Creative Living, CP and CORE residential provider,
- Walsh and Associates, CP residential providers
- Spokane County Development Disability Division, Employment Contractor
- ARC of Spokane, Employment Contractor
- Yakima County, Residential and Employment Contractor

Additionally, CMS received comments from advocacy groups including:
- ARC of Washington
- Washington Protection and Advocacy System
- Columbia Legal Services

Other Federal Agencies which were involved in the review:
- Agency for Children and Families

Recommendations:

1. The Division did not provide sufficient evidence that it assures that training programs were available for review by relevant staff especially staff of agencies that work with the client. The State must maintain records of these trainings, monitoring review, and all other oversight activities.
2. The Division lacks sufficient evidence that it has the State developed formal written training programs that described methods to be used, measurable objectives, data and frequency of data collection necessary to client needs and be able to assess programs

toward meeting those needs. The State must develop the appropriate protocols which reflect the formal training program as well as documentation that the training occurred.

3. The Division must provide stronger oversight for clients in the Community Protection Waiver. Although, according to the State, there have been no incidents involving the community; there were several instances of elopement and/or assaultive behavior as documented in the clinical records. The State must immediately develop a more comprehensive plan for monitoring incidents, even non-community based, responding, and implementing timely and effective interventions.
4. The Division lacks sufficient evidence that it monitor programs provided by individuals and agencies to assure that they were being implemented consistently and correctly. The State must develop and retain evidence of this monitoring.
5. The Division must establish an oversight system for all its providers. Special reference is made to those clients that receive services from the School systems and Community Protection waiver services providers. All services provided to DD waiver clients are the oversight responsibility of the Division.
6. Community Protection (CP) and CORE waiver participants appear to be receiving insufficient day services, especially in terms of employment options.
7. Advocates, consumers, patient representative, and providers were asked to provide comments regarding these waivers. The most prevalent comment was a concern about division of the CAP (Community Alternative Protection Waiver #50) into four individual levels of service waivers. Stakeholders, of all varieties, believe that this waiver division insures that clients are not in the appropriate waiver, and are placed on "waiting list" and that client needs are not adequately addressed. These waivers are defined by historical funding levels, which as an approach, increase the likelihood that clients will not have all currently assessed needs met.
8. The stakeholder input received specified the following areas of continuing problems and concerns:

    - Access to services and providers is not uniform and/or adequate across the State.
    - Inconsistent record of oversight of providers.
    - Services are implemented by counties, which allow employment providers to look for a job for the client for up to two years. During that time the client is prohibited from receiving other help.
    - Plans of Care (POC) and assessment processes are inadequate.
    - Lack of due process for clients moving between waivers.
    - Requires Community/Public Safety (PCC) clients be enrolled in the waiver or receive only State Plan services.
    - Community Protection Clients with behavioral health diagnosis are not allowed by the state to use crisis diversion beds.
    - Adult Protective Service does not perform "adequate" investigations when dealing with the mentally retarded/developmentally disabled client.
    - Training to care for the Community Protection Client.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.
Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

The state substantially meets this assurance

Evidence:

1. Incident reports.
2. Monthly incident reports.
3. Incident reporting policies and procedures.
4. Staffing plans.
5. Washington State Core Indicator Workgroup Report, July 2005.
6. Quality Management Plan.

Comments:

1. The Incident reporting system and reports from the system were reviewed, as were the team meeting and committee minutes.
2. The Division provided evidence that Incident Reports monitoring results were reviewed and acted on by the management.
3. The DDD incident reporting system including the (a) management notification, (b) case management tool, and (c) quality assurance tools are fully implemented. This is a significant improvement over the previous system.
4. The Division has instituted Incident Management/Mandatory Reporting training for all field staff. Additionally, the Division is monitoring the effectiveness of the training.
5. The Division is performing a monthly analysis of Incident Reporting Data. This monitoring includes investigation of variations, including a Pareto analysis.

Recommendations:

1. Although significantly improved, the State should increase in the number of case managers. The current case load standard is 75 to 1. This is a significant work load for individuals who must insure the health and welfare of severely compromised clients. CMS findings are substantiated in detail in the report of the Developmental Disability Council, "Washington State Core Indicators Workgroup Findings", July, 2005.
2. The Division needs to develop an "executive summary" of its extensive Quality Management Plan. To prepared the State to prepare the State to complete the renewal waiver format.
3. The Senior Management must annually review and approve the MR/DD Quality Management Strategy.
6. The Division should work closely with the Adult Protective Services (APS) regarding definitions of incidents, which more adequately reflect the needs of the population being served in the MR/DD waivers.

V. State Medicaid Agency Retains Administrative Authority over the Waiver Program

The State must demonstrate that it retains administrative authority of the waiver program and that its administration of the waiver program is consistent with its approved waiver application.
Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

The State substantially meets this assurance

Evidence:

1. Organization charts
2. Policies and Procedures

Recommendations:

There are no recommendations at this time.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.
Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

The State substantially meets this assurance

Evidence:

CMS reviewed the following evidence provided by the State:
1. Social Services Payment System (SSPS) and Financial Reporting System (FRS) crosswalk-evidence of waiver account coding.
2. Client Authorization Services Implementation System (CASIS) edits for evidence that expenditures are coded to the correct waiver.
3. County Human Resources Implementation System (CHRIS) reports provide evidence of waiver account coding for county based services.
4. CMS 64 reports, which provide evidence waiver expenditures claimed as appropriate.
5. The Decision Support Reports which document ongoing monitoring of waiver expenditures.
6. Payment Review Program (PRP) algorithms, evidence of payment monitoring.
7. SSPS Case File Review Database an internal monitoring tools.
8. QCC Waiver file review Q #10, as evidence of internal monitoring.
9. State waiver oversight committee minutes.

The Washington State MR/DD (Mental Retardation/Developmental Disability) waiver programs are currently over budget resulting in a deficit in funds. CMS met with two Washington state

fiscal department managers to discuss this subject and what actions, if any, the state is taking to prevent this situation from happening again and what caused this situation to occur.

The state has been in a deficit for this program in prior years, just not to this extent. The state specified the following as reasons for the shortfall this year:

A. Health and Safety Issues
B. Needs Changes/behavior changes
C. Once a proviso year is over, the funds must come out of the general appropriated funds the next full year, which may not have been allotted for in the budget
D. Maintenance level of care funding
E. More clients are going into institutions

In the past, money has been moved from different divisions to cover the deficit in the DDD (Division of Developmental Disabilities) area and has been handled within the division. This year, the new Governor has stressed accountability within each division's budget which in turn, highlighted the deficit in the DDD area. The DDD department does expect funds to be moved from other departments to cover this year's deficit. Borrowing from next year's budget is not allowed.

The Division has taken steps to try to correct this problem for future years and these are listed below.

A. Economy of scale – if there is room for a third person in a residential facility, move someone into that opening, thus filling up residences to maximum capacity. By doing this, it will reduce costs by combining clients and in turn, closes up other un-used residences. This does have a quality of life issue if the person being incorporated into the original household is disruptive or physically abusive, etc.

B. There is a new Assessment Tool being designed to be in effect in 2008. This tool has the potential to raise the rates paid, but the hope is it will lower or maintain the rates at the present level.

C. The Division has hired a budget person who is currently writing up a savings document designed to help the department cut costs. This document is still in draft form and not yet released to the department.

The budget is reviewed on different levels of the state. Quarterly, the Regional offices meet with the Central Officer personnel to review the budget. Once a month, the Central Office budget person, the Budget office representative, and the Deputy Secretary meet to analyze and review the budget. It would appear the state is aware of the budget deficit at an early stage.

The funds start out as an appropriation made at the Legislation level, from there the funds are allotted out to the Division, and then further allotted out to the Regional Offices who pay the money out to the provider. Once the funds have been paid to the provider, the expenditure is entered into the DSHS system for inclusion on the CMS 64. At this point, how the client is

coded determines if the funds are coded as Federal Match expenditures or State expenditures only.

The State receives the majority of it's funding from Medicaid. There is almost no non-Federal funding received. Once a client is established in the system, the client is coded as being a state funded client or a waiver client. The main payment system is the Social Service Payment System (SSPS). Almost over 95% of all payments are made through this system. The MMIS system is used only for private pay ICF/MR (Intermediate Care Facility/Mental Retardation), which includes approximately 60 clients. The other system is the SOLA system, where workers are paid like they were "state employees". This is an old program and was done when the institutions closed, the concept was that people would feel more comfortable being serviced by state employees. This payment system pays on a yearly projected basis with a reconciliation done at year end. Then a debit or credit is sent to CMS. Usually it is a debit since the amount paid during the year is lower than what the state thinks will be the actual amount due.

The SSPS system performs as follows: Once a contract is in place, the rate information is sent to Central Office for approval. Once this has been completed, this rate amount is entered into SSPS. The Regional manager enters the authorized number of days for which a client is eligible for a specific month. This information has to be entered by the end-of-month cut-off. After the first of the following month, an invoice of authorized hours is sent to the provider. The provider signs and certifies that the authorized number of hours was the actual number of hours performed, or makes any adjustments needed and sends the invoice back to the Regional Manager for input into the SSPS system for payment. Payment is usually made by the 10th of the month. An audit is completed on the provider as State staff time allows.

The rates are set by the state for residential and all other services, and by the county for day/employment services and are affected by many factors, including, but not limited to, what service is provided, what area of the state the clients is in, to what type of residential setting is provided, etc. Proviso funding, where the Legislature sets aside a certain amount of money for a specific program or number of clients, is manually tracked separately. Proviso funding is allowable for FFP, but these funds cannot be used to fund any other program, only what was mandated by the Legislature.

The State needs to provide better oversight to the providers to ensure that the number of hours being certified was actually delivered. The current process pays based on a signed certification invoice with no additional back up documentation attached. An audit should be completed ensuring that the number of hours authorized conforms to the POC, the service is being delivered to the individual as identified in the POC, and the rate paid for this client covers all the services the client needs or is entitled to.

The Division needs to stay within the yearly budget and monitor the expenditures more closely. Actions must be taken to save money within the program or decide on avenues to cut back in order to stop the excess expenditures. It seems that the division and state are aware of the status of the budget, but in the past no action has been taken to bring the budget back into good standing.

Recommendations:

1. The Division needs to stay within the yearly budget.
2. The State needs to establish a system to more closely monitor the expenditures.
3. The Division must accept responsibility for insuring that all waiver clients receive the services identified on the individual care plan, without regarding to budget considerations.

ACRONYMS

AAA-Area Agencies on Aging

ADSA-Aged and Disabled Services Administration

APSAS–Adult Protective Service Automated Systems

CA-Community Assess (day service program)

CAP-Corrective Action Plan

CARE- Comprehensive Assessment, Reporting, & Evaluation (tool)

CDS-Child Development Services

CMS-Centers for Medicare & Medicaid Services

DOH–Department of Health

GSE-Group Supported Employment

HCBS-Home and Community Based Services

HCS-Home and Community Services

HQ-Headquarters

IE-Independent Employment

IFA-Individual and Family Assistance

LOC-Level of Care

POC-Plan of Care

PTP-Person to Person (day program)

QA-Quality Assurance

QI-Quality Improvement

QC-Quality Committee

QAS-Quality Assurance Survey

RCW-Revised Code of Washington

SI-Special Industries (pre-vocational services)

SSPS-Social Services Payment System

WAC-Washington Administrative Code